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Building Capacity for Self-Management Interventions: The Challenges

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Introduction

It has been five years since the Affordable Care Act was signed and much attention has been focused upon website problems, delays in implementation, litigation and less than universal expansions of Medicaid in different states, as well as successes in signing people up, and increases in the numbers of people covered by health insurance, particularly young adults and those with pre-existing conditions. Increased coverage is not the only outcome desired; transformations in the delivery of health care have also been purposefully advanced including achieving better health, better care and lower cost, and implementation of incentives and penalties related to addressing healthcare goals. Care Transition, Accountable Care Organization, Patient Centered Medical Home, Preventive Health and bundled payment mechanisms are advancing change throughout the U.S. by responding to health management concerns with holistic, person in environment and patient as partner emphases.

Self-management of their conditions by patients, person-centered care, multidisciplinary approaches and the value of partnerships with community based agencies are being discovered, sometimes as if they are new concepts. And in many ways they are “new” as they did not feature prominently in past healthcare delivery but now are at the forefront of moving healthcare from an acute to a chronic care focus. These ideas are embedded in theoretical perspectives such as the Chronic Care Model [1] driving healthcare reform and supporting growing use of low cost evidence and community-based interventions. They have their own models for widespread dissemination (e.g., the expanded Chronic Care Model and the RE-AIM Framework) but are challenged by (1) poor understanding of the value and availability of evidence-based self-management interventions; (2) skepticism among professionals and providers, (3) a lack of linkages of program need and delivery particularly in electronic exchange of information, and (4) still to be established reimbursement mechanisms. Resolving these challenges will be the next critical step for healthcare reform and nurses and other healthcare professionals must decide if they are ready to be the innovators who will realize the potential of these approaches.

The Chronic Care Model

The Chronic Care Model was developed to offer a framework that moves the system

- from acute care to chronic condition management
- to inform the greater development of therapeutic relationships built upon proactive patients actively managing their conditions in collaboration with thoughtful, energized and collaborative care practice teams of healthcare professionals interacting with community-based providers supporting patient actions outside of healthcare services and ongoing self-management success [1].

Barr and colleagues [2] have taken the model further, arguing that a more expansive population health promotion approach better incorporates prevention efforts, responds to social determinants of health concerns, and encourages enhanced community participation to support the work of health system teams responding to chronic diseases. Taken together, these ideas underpin efforts at healthcare reform.

Less clear is the level of understanding and commitment to this approach in the preparation of healthcare professionals and in the availability and utilization of interventions likely to support comprehensive, team based, and self-management among patient approaches.

Skepticism among Professionals and Providers

Change rarely happens simply from stated intent; instead there is a need for sustained and committed action with administrative, educational and professional support. Hibbard and colleagues [3] in their promotion of strategies to raise the levels of activation to undertake self-management among patients have also raised that while healthcare professionals are not always enthusiastic about treating patients as partners in care independently seeking information, making decisions and taking actions to advance their care (cornerstones of self-management). This leads to questions as to how well codes of professional conduct, educational and continuing education programs and provider procedures actively support and prepare/require professionals for these advances. Hibbard and colleagues [3] concluded their study raising the question of what additional support healthcare professionals need. We argue that healthcare professionals and providers must become more aware of evidence-based self-management interventions, incorporate their use in health related care, do more with community based agencies to link data from such interventions in electronic exchanges of information and find ways to support the related reimbursements that will ensure their widespread and sustainable availability.

Evidence based Interventions to Support Increased Health Related Self-management Practice and Success among Patients

Health related self-management practice is focused upon enhancing positive health, reducing the risk of ill health, and managing both the consequences and improving the prognosis when chronic disease is present [4]. The interventions may include self-management tasks: medical, role and emotional management; skills in: decision-making, problem-solving, building patient/provider partnerships, resource utilization, action planning and tailoring responses [5]; and health related behavior changes targeting modifiable risk factors for disease:

e.g., smoking cessation and increased physical activity and healthy eating [4]. Underlying processes include building a sense of empowerment and self-efficacy, often through the experience and reinforcement of success, recognizing that social and environmental factors are to be influenced as well as individual behaviors [6], and understanding that the intervention setting and leader are also of influence [4]. Interventions may be brief (perhaps weekly for 6 weeks) or extended (for a year or more), have closed memberships or individuals may enroll or stay at will, and may be professional or lay-leader led.

Evidence for the effectiveness of health related self-management practice does vary with examples such as the Chronic Disease Self-management Program with multiple randomized control trials completed with diverse populations [7], and the Diabetes Prevention Program tested over extended periods of time [8] to one time, quasi-experimental studies. The more robust studies have helped establish the characteristics of successful programs: content related to purpose and underlying change process assumptions, manualized approaches, fidelity requirements, and standardized training [9].

The incorporation of such interventions into the more holistic approaches advanced by the Affordable Care Act continues to be stymied, however, not just by the professional skepticism mentioned earlier but also by the emphasis in the clinical training of practitioners on the successful demonstration of clinical skills. Successful use of and collaboration with evidence-based health related self-management practice, particularly when the interventions are community delivered require skills in participatory and empowerment practice and collaboration and an understanding of activities to overcome policy and access barriers that are still too rarely part of health professional training [10]. That such interventions are usually not reported in electronic records or embedded in reimbursement systems adds to the difficulty.

Linkages to Electronic Exchange of Information

To reduce paperwork, costs and medical errors, the Affordable Care Act has called for building capacity to rely upon the secure electronic exchange of health information. Electronic health and electronic medical records systems increasingly exist but their cost means that community based agencies and even some small health care practices do not fully participate. Supporting and enabling bidirectional feedback and linkages regarding interventions that build patient self-management seems critical. As the reliance upon electronic exchanges increase, opportunities for connection to programs will be lost if there are not mechanisms to identify those who would benefit and then to electronically link those patients to interventions. Equally, it will be increasingly challenging for the work of community agencies and for the self-management activities of patients to feature as key components in care plans if there are not mechanisms for this work to be captured in those records. Our own work in New York currently includes efforts to build an electronic data system capable of communicating with electronic records on behalf of community agencies delivering evidence based interventions.

Reimbursement mechanisms

A change in the way healthcare for chronic conditions is approached will not genuinely occur if there is not an opportunity for

reimbursement. A ‘free’ service, first is not actually ‘free’ and second will not be effectively utilized by healthcare systems; free is not seen as available, reliable and valuable. In many ways, no matter how efficacious, evidence-based, health-related, self-management practice will continue to be under-utilized, as will the resulting self-management activities of patients if they do not feature as a service to be counted and reimbursed. The Affordable Care Act and the resulting changes offer both traditional and new mechanisms for reimbursement (direct or as a share of savings achieved, penalties avoided or incentives received). In an environment where costs are to be managed overall these interventions are competing for reimbursement with more established and clinically delivered protocols. To the extent community delivered evidence-based interventions result in health improvement and lower costs for patients they should be supported, but without the changes in chronic condition approach that the Affordable care Act seeks to achieve including the elimination of past interventions not fit for purpose and sharing of resources with new partners, this will not occur.

Evidence-based, health-related, self-management practice interventions in support of new partnerships and new approaches to chronic care management promise success in healthcare reform but only if healthcare professionals believe, include these ideas in training, seek changes in reimbursement and act courageously.

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